

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> 0731 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>David D. Bailey</u>			4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-37</u>		9. AGE (in years last birthday) <u>22</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plastic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Theodore H. Bailey</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Janifer</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>219-34-2084</u>		17. INFORMANT <u>Theodore H. Bailey</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Corobrum</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u>					
20c. TIME OF INJURY Month, Day, Year <u>1-26-1960</u> Hour <u>1</u> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Joppa</u>		(County) <u>Harford</u>		(State) <u>MD.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u>				
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>1-27-60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 27 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>			
22d. LOCATION (City, town, or county) <u>Abingdon, Harford, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>			ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

00709

0713

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harvre de Grace</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>819 Adams Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Estella</i> Middle <i>Barnes</i> Last <i>Barnes</i>		4. DATE OF DEATH Month <i>1</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 25, 1924</i>
9. AGE (In years last birthday) <i>36</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.	11. IF UNDER 24 HRS. Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Harvre de Grace, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>No Record</i>		14. MOTHER'S MAIDEN NAME <i>Esther Barnes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Albert Stotters</i> Address <i>5532 Boyer St Phila, 38 Pa</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myo cardiac Infarction</i> 292.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>Sickle Cell Anemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>1 hour</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/23/1960</i> to <i>1/26/1960</i> that I last saw the deceased alive on <i>1/29/1960</i> , and that death occurred at <i>11:00 AM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Irvin L. Wachsman</i> M.D.		ADDRESS (Street, city or town, state) <i>407 S. Union Ave Harvre de Grace, Md</i>	
PHYSICIAN'S NAME (Type) <i>IRVIN L. WACHSMAN</i>		DATE SIGNED <i>1/29/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/29/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Harlington, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Bullock, Harvre de Grace, Md</i>		24a. REC'D BY REGISTRAR <i>Jan 29 1960</i>	24b. REGISTRAR'S SIGNATURE <i>Charles J. Bullock</i>

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00710

0714

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre-de-Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Perryman</i>			
c. LENGTH OF STAY IN 1b <i>14 days</i>				d. STREET ADDRESS <i>R. F. D. # 1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Phillip Thomas Buchanan</i>				4. DATE OF DEATH Month <i>1</i> Day <i>14</i> Year <i>1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 26, 1881</i>	
9. AGE (In years last birthday) <i>78 yrs.</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>18</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handy man</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Trailer Camp</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Thomas Buchanan</i>				14. MOTHER'S MAIDEN NAME <i>Frances Jinson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>220-05-8444</i>		17. INFORMANT Address <i>Mrs. Rebecca Buchanan - Perryman MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i>Generalized Arteriosclerosis & Cerebral Sclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/31</i> , 19 <i>59</i> , to <i>1/14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/14</i> , 19 <i>60</i> , and that death occurred at <i>7:05 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution St. Harre-de-Grace, Md.</i> DATE SIGNED <i>1/15/60</i>							
ACTUAL SIGNATURE <i>George T. Stansbury</i>				PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>1-19-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia S. Bullock - Harre-de-Grace, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 19 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0715 CERTIFICATE OF DEATH

Reg. Dist. No.

00711

1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> d. STREET ADDRESS <i>Groves Hill RD #2</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Emma</i> Last <i>Bunce</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/27/1875</i>
9. AGE (In years lost birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William H. Fletcher</i>		14. MOTHER'S MAIDEN NAME <i>Laura Emma Marshall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Debility - Carcinomatous</i> 151X DUE TO (b) <i>(Stomach)</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/23</i> , 19 <i>59</i> , to <i>1-24-60</i> , that I last saw the deceased alive on <i>1/24</i> , 19 <i>60</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Harre de Grace, Md.</i> DATE SIGNED <i>1/25/60</i>			
ACTUAL SIGNATURE <i>C. L. Lewis</i>		PHYSICIAN'S NAME (Type) <i>C. L. Lewis</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1/27/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick J. ...</i>		24a. REC'D BY REGISTRAR <i>...</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

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2
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069
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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

My dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the purchase of the land for the proposed new site of the Army Medical School at Fort Belvoir, Chicago, Illinois. The matter is being considered by the War Department and the War Relocation Authority, and it is expected that a decision will be reached within a few days.

I am, Sir, very respectfully,
Your obedient servant,
John D. Smith
Secretary of the Army

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00712

Reg. Dist. No.....

0732

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROBAL-BEL AIR</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD NURSING HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROBAL-HAVRE DE GRACE</u> STREET ADDRESS (If rural give location) <u>1 Star Route</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOHN EMANUEL BURKENTINE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 22 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>DEC. 25, 1880</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT BURKENTINE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH CONNOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-9610</u>		17. INFORMANT & ADDRESS <u>MRS. John SAVIN HAVRE DE GRACE MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 151X IMMEDIATE CAUSE (A) <u>Carcinomatous</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of stomach & intestines</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-14-59</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of stomach & intestines & obstruction</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12-1-59</u> , to <u>1-19-60</u> , that I last saw the deceased alive on <u>1-19-60</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Brender</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>Havre de Grace 1-23-60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN. 24 1960</u>		NAME OF CEMETERY OR CREMATORY <u>ROCK RUN</u>		LOCATION (City, town, or county) (State) <u>HARFORD MD</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>		REGISTRAR'S SIGNATURE <u>William S. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD</u>	

CERTIFICATE OF DEATH

REG. DIST. NO.

1. HUSBAND RESIDENCE (NAME OF DECEASED)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BURIAL

10. NAME OF BURIAL PLACE

11. NAME OF MINISTER

12. NAME OF WITNESSES

13. NAME OF CORONER

14. NAME OF JURY

15. NAME OF JUDGE

16. NAME OF CLERK

17. NAME OF SHERIFF

18. NAME OF DEPUTY SHERIFF

19. NAME OF CONSTABLE

20. NAME OF JURY

21. NAME OF JUDGE

22. NAME OF CLERK

23. NAME OF SHERIFF

24. NAME OF DEPUTY SHERIFF

25. NAME OF CONSTABLE

26. NAME OF JURY

27. NAME OF JUDGE

28. NAME OF CLERK

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MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH May 15, 1901	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. EDUCATION High School	
9. PRESENT RESIDENCE 1234 Elm St., Baltimore, Md.		10. DATE OF DEATH May 20, 1946	
11. CAUSE OF DEATH Myocardial Infarction		12. MANNER OF DEATH Natural	
13. SIGNATURE OF EXAMINER J. H. Smith, M.D.		14. SIGNATURE OF DECEASED James H. Harris	
15. SIGNATURE OF WITNESSES John D. Jones, M.D. Mary E. White, M.D.		16. SIGNATURE OF FUNERAL HOME The Baltimore Funeral Home	
17. SIGNATURE OF NEAREST RELATIVE Mrs. J. H. Harris		18. SIGNATURE OF CLERGYMAN Rev. J. H. Harris	
19. SIGNATURE OF JURY Jury of the County of Baltimore		20. SIGNATURE OF JUDGE Judge J. H. Harris	
21. SIGNATURE OF DISTRICT ATTORNEY District Attorney J. H. Harris		22. SIGNATURE OF CLERK Clerk J. H. Harris	
23. SIGNATURE OF SHERIFF Sheriff J. H. Harris		24. SIGNATURE OF CORONER Coroner J. H. Harris	
25. SIGNATURE OF JURY Jury of the County of Baltimore		26. SIGNATURE OF JUDGE Judge J. H. Harris	
27. SIGNATURE OF DISTRICT ATTORNEY District Attorney J. H. Harris		28. SIGNATURE OF CLERK Clerk J. H. Harris	
29. SIGNATURE OF SHERIFF Sheriff J. H. Harris		30. SIGNATURE OF CORONER Coroner J. H. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 2-8-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. **00714**

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rurää Baldwin		c. LENGTH OF STAY IN 1b 69 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Paul Dalton		4. DATE OF DEATH Jan 31 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. farming	
11. BIRTHPLACE (State or foreign country) Baldwin, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Dalton		14. MOTHER'S MAIDEN NAME Viole Shawn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Charles B. Dalton		Address Baldwin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Hypertensive Cardiovas. Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 15 yrs DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis lower extremities from birth.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 10, 1940, to 1/31, 1960, that I last saw the deceased alive on 1/31, 1960, and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson M.D.		ADDRESS (Street, city or town, state) FORK, MD.	
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/1960	
22c. NAME OF CEMETERY OR CREMATORY St Johns		22d. LOCATION (City, town, or county) (State) Hydes Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kuntz		24a. REC'D BY REGISTRAR FEB 4 '60	
ADDRESS Jarrettsville		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, L.A. Motel, Memphis, Tenn.	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Miss.	
10. OCCUPATION Minister of the Gospel		11. EDUCATION High School		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF CORONER [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED'S NEXT OF KIN [Signature]		20. SIGNATURE OF DECEASED'S ATTORNEY [Signature]		21. SIGNATURE OF DECEASED'S MINISTER [Signature]	
22. SIGNATURE OF DECEASED'S PASTOR [Signature]		23. SIGNATURE OF DECEASED'S FRIEND [Signature]		24. SIGNATURE OF DECEASED'S NEARER OF KIN [Signature]	
25. SIGNATURE OF DECEASED'S NEARER OF KIN [Signature]		26. SIGNATURE OF DECEASED'S NEARER OF KIN [Signature]		27. SIGNATURE OF DECEASED'S NEARER OF KIN [Signature]	
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THIS CERTIFICATE IS A STATUTE OF THE STATE OF MARYLAND. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN A RECORD OF THE DEATHS OF ALL PERSONS WHO DIE IN THIS STATE. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00715

0735

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>Fountain Green Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> <u>May</u> <u>Foy</u> First Middle Last				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1960</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Jefferson, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert Lee Walters</u>				14. MOTHER'S MAIDEN NAME <u>Callie Jane Dickson</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>234-07-7743B</u>		17. INFORMANT Address <u>Chester W. Foy Bel Air, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastatic carcinoma (original site)</u> DUE TO (b) <u>carcinoma of the breast.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>February</u> <u>1950</u> , to <u>January 15</u> <u>1960</u> , that I last saw the deceased alive on <u>January 15</u> <u>1960</u> , and that death occurred at <u>6:00 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____											
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> <u>January 16, 1960</u>											
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>			22d. LOCATION (City, town, or county) <u>Fountain Green, Maryland</u> (State) _____				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Fultz</u>						ADDRESS <u>Faussettville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Fultz</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0736

CERTIFICATE OF DEATH

00716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rd. #2, Box 7				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle H. Last Green				4. DATE OF DEATH Month January Day 17 Year 19 60			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 October 1881	
9. AGE (In years last birthday) 78 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jacob Green			
14. MOTHER'S MAIDEN NAME Mary Presbury				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-03-6963				17. INFORMANT Florence K. Green, Rd. #2, Box 7, Forest Hill, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) Chronic Cardio-vascular Disease							INTERVAL BETWEEN ONSET AND DEATH 20 minutes ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 31 , 19 51 , to January 17 , 19 60 , that I last saw the deceased alive on January 11 , 19 60 , and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED 1/18/60							
ACTUAL SIGNATURE Willard P. Hudson M.D.							
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/1960		22c. NAME OF CEMETERY OR CREMATORY Fair View Methodist		22d. LOCATION (City, town, or county) (State) Harf. Co. Forest Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Foster w. Broadway and Williams St. BALTIMORE, Maryland				24a. REC'D BY REGISTRAR DATE JAN 20 '60		24b. REGISTRAR'S SIGNATURE William S. Kneass	

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1900-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
New York City		1950-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Age at Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
50 years		1950-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
1950-01-01		1950-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Time of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
10:00 AM		1950-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Signature of Physician		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Doe, M.D.		1950-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Signature of Registrar		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Doe, M.D.		1950-01-01		Male		White		Married		Teacher		Heart Disease		Home		1950-01-01		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0737 CERTIFICATE OF DEATH

Reg. Dist. No.

00717

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD Rocks</u>			c. LENGTH OF STAY IN 1b <u>4 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL Air RD #3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rocks of Deer Creek Rest Home</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>S. Groseclose</u> Middle Last				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Bland Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Groseclose</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-26-8618A</u>		17. INFORMANT <u>G. Stewart Groseclose</u> Address <u>Box 174 BEL Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEVERE DEBILITATION - CARDIAC FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SENILE PSYCHOSIS</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>6 MOS</u> <u>OVER 5 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BENIGN PROSTATIC HYPERTROPHY - POST OPERATIVE 7 WKS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 1</u> , 19 <u>60</u> , to <u>JAN 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 20</u> , 19 <u>60</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. <u>307 HICKORY</u>				<u>JAN 26, 1960</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN</u>				<u>BEL AIR, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>BEL Air, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway & Williams St. BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Conrad S. Tims</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

FILE NO.

MADE IN U.S.A.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
John Doe		Male		45		1/1/1920		Boston, Mass.		Teacher		Heart Disease		Natural		[Signature]		[Signature]	
11. PLACE OF DEATH		12. TIME OF DEATH		13. SEX		14. AGE		15. DATE OF DEATH		16. PLACE OF DEATH		17. CAUSE OF DEATH		18. MANNER OF DEATH		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	
Home		10:00 AM		Male		45		1/1/1920		Boston, Mass.		Heart Disease		Natural		[Signature]		[Signature]	
21. PLACE OF DEATH		22. TIME OF DEATH		23. SEX		24. AGE		25. DATE OF DEATH		26. PLACE OF DEATH		27. CAUSE OF DEATH		28. MANNER OF DEATH		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR	
Home		10:00 AM		Male		45		1/1/1920		Boston, Mass.		Heart Disease		Natural		[Signature]		[Signature]	

MADE IN U.S.A.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

Reg. Dist. No.

00718

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hare de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Hare de Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>116 N. Washington St</i>		d. STREET ADDRESS <i>116 N. Washington St</i>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>Haberman</i> Last <i>Haberman</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>1</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1905</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Store</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Late Jacob Haberman</i>		14. MOTHER'S MAIDEN NAME <i>Rose Talman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>420.1</i>	
17. INFORMANT <i>Gertrude Haberman - 116 N. Washington St</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/31</i> , 1959, to <i>6/11</i> , 1960, that I last saw the deceased alive on <i>6/11</i> , 1960, and that death occurred at <i>3 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur H. Wadsworth, M.D.</i>		ADDRESS (Street, city or town, state) <i>407 S. Union Ave</i>	
PHYSICIAN'S NAME (Type) <i>HAURE De GRACE, MD</i>		DATE SIGNED <i>6/11/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 3/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hebrew Friendship</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Lenson</i>		24. REC'D BY REGISTRAR DATE <i>JAN 6 '60</i>	
ADDRESS <i>1124-26 W. North Ave</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

00719

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Cecil ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT 07X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		d. STREET ADDRESS 184 N. MAIN ST.	
3. NAME OF DECEASED (Type or print) CAROLINE HATTIE HENRY		4. DATE OF DEATH JANUARY 20 1960	
5. SEX FEMALE	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1908
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Hopkins		14. MOTHER'S MAIDEN NAME FLORENCE ALEXANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Josiah Fields, 184 main St. Port Deposit	
17. INFORMANT Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of the Ovary DUE TO (c) Metastatic Carcinoma of the Ovary		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/2 , 19 60 , to 1/20 , 19 60 , that I last saw the deceased alive on 1/20 , 19 60 , and that death occurred at 6:25 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Stansbury M.D.		ADDRESS (Street, city or town, state) 569 Revolution St. Harre de Gray, Md. DATE SIGNED 1/20/60	
PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Type) Burial	22b. DATE THEREOF 1-23-1960	22c. NAME OF CEMETERY OR CREMATORY Mt. Zoar Cem.	22d. LOCATION (City, town, or county) (State) Conowingo, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son, ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR AN 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove棺盒 papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. US BIRTH [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. OCCUPATION [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. MEDICAL HISTORY [REDACTED]		11. PRESENT ILLNESS [REDACTED]		12. DATE OF DEATH [REDACTED]	
13. PLACE OF DEATH [REDACTED]		14. SIGNATURE OF DECEASED [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]	
16. SIGNATURE OF PHYSICIAN [REDACTED]		17. SIGNATURE OF REGISTRAR [REDACTED]		18. SIGNATURE OF CLERK [REDACTED]	



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY ANY OTHER OFFICIAL.

0718 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shore de Grace</u>	c. LENGTH OF STAY IN TB <u>2 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>569 Revolution St.</u>		d. STREET ADDRESS <u>R.F.D. #1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Benita</u> Middle <u>Hill</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1960</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. <u>1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Shore de Grace, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Stanford Hill</u>	
14. MOTHER'S MAIDEN NAME <u>Pearl Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mr. Stanford Hill - R.F.D. #1, Bel-Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>112</u> 19 <u>60</u> , to <u>117</u> 19 <u>60</u> , that I last saw the deceased alive on <u>117</u> 19 <u>60</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>569 Revolution St. Shore de Grace, Md. 1/8/60</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-9-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Falmouth, Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock</u>		ADDRESS <u>Shore de Grace, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Charles J. Bullock</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0719 CERTIFICATE OF DEATH

Reg. Dist. No. 00721

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVEY DE GRACE		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville Rural 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARVEY MEMORIAL HOSPITAL				d. STREET ADDRESS Susquehanna Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KENDALL CHARLES HILL				4. DATE OF DEATH Month Day Year JANUARY 11 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1910	9. AGE (In years lost birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cobbler		10b. KIND OF BUSINESS OR INDUSTRY Shoe Shop		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Hill				14. MOTHER'S MAIDEN NAME Eleanor Fox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1929-1932		17. INFORMANT Address Mrs John E. Little, Sr. Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia, both lower lobes DUE TO Cardiac decompensation due to Cor pulmonale and asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthmatic bronchitis + Cor pulmonale						INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3rd, 1960 to Jan 11th, 1960 that I last saw the deceased alive on Jan 11th, 1960 and that death occurred at 1:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Lee, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. M.D.		DATE SIGNED 1/11/60	
PHYSICIAN'S NAME (Type) Edward C. Lee, M.D. Harvey de Grace, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		22b. DATE THEREOF 1-13-1960		22c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel		22d. LOCATION (City, town, or county) (State) Aberdeen, Md., Rural	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson, Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0709 CERTIFICATE OF DEATH

Reg. Dist. No.

00722

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>608 Ridgewood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lee</u> Last <u>Irwin</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>24th</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 23, 1882</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former Lumberman</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Irwin</u>				14. MOTHER'S MAIDEN NAME <u>Ava Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-4101</u>		17. INFORMANT <u>Cornelius Provine - 608 Ridgewood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis - Monia ?? (3 mo.)</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 years</u> <u>5 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>JAN. 24, 1960</u> , that I last saw the deceased alive on <u>JAN. 24, 1960</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Richardson, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u>		DATE SIGNED <u>1/24/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles Richardson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 26, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barron, Chesapeake Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>0710</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>			
c. LENGTH OF STAY IN 1b <u>25 yrs.</u>				d. STREET ADDRESS <u>1 Williams Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williams Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel S. Jackson</u>				4. DATE OF DEATH Month Day Year <u>January 5 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 10, 1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Smith</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-32-1150</u>		17. INFORMANT Address <u>Mrs. Hester Fisher Williams Street Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>1-5-60</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joseph W. Foster W. Broadway + Williams St. Bel Air, Maryland</u>				24a. RECEIVED BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, filing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director; Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. RACE <u>White</u>	
5. DATE OF DEATH <u>Jan 15, 1920</u>		6. TIME OF DEATH <u>10:30 AM</u>	
7. PLACE OF DEATH <u>Home</u>		8. STREET <u>1234 N. E. St.</u>	
9. CITY <u>Baltimore</u>		10. COUNTY <u>Harford</u>	
11. STATE <u>Md.</u>		12. ZIP CODE <u>21201</u>	
13. OCCUPATION <u>Engineer</u>		14. CAUSE OF DEATH <u>Heart Disease</u>	
15. MANNER OF DEATH <u>Natural</u>		16. SIGNATURE OF EXAMINER <u>[Signature]</u>	
17. SIGNATURE OF WITNESS <u>[Signature]</u>		18. SIGNATURE OF CLERK <u>[Signature]</u>	
19. SIGNATURE OF JURY <u>[Signature]</u>		20. SIGNATURE OF JUDGE <u>[Signature]</u>	
21. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		22. SIGNATURE OF DEFENSE <u>[Signature]</u>	
23. SIGNATURE OF JURY <u>[Signature]</u>		24. SIGNATURE OF JUDGE <u>[Signature]</u>	
25. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		26. SIGNATURE OF DEFENSE <u>[Signature]</u>	
27. SIGNATURE OF JURY <u>[Signature]</u>		28. SIGNATURE OF JUDGE <u>[Signature]</u>	
29. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		30. SIGNATURE OF DEFENSE <u>[Signature]</u>	
31. SIGNATURE OF JURY <u>[Signature]</u>		32. SIGNATURE OF JUDGE <u>[Signature]</u>	
33. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		34. SIGNATURE OF DEFENSE <u>[Signature]</u>	
35. SIGNATURE OF JURY <u>[Signature]</u>		36. SIGNATURE OF JUDGE <u>[Signature]</u>	
37. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		38. SIGNATURE OF DEFENSE <u>[Signature]</u>	
39. SIGNATURE OF JURY <u>[Signature]</u>		40. SIGNATURE OF JUDGE <u>[Signature]</u>	
41. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		42. SIGNATURE OF DEFENSE <u>[Signature]</u>	
43. SIGNATURE OF JURY <u>[Signature]</u>		44. SIGNATURE OF JUDGE <u>[Signature]</u>	
45. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		46. SIGNATURE OF DEFENSE <u>[Signature]</u>	
47. SIGNATURE OF JURY <u>[Signature]</u>		48. SIGNATURE OF JUDGE <u>[Signature]</u>	
49. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		50. SIGNATURE OF DEFENSE <u>[Signature]</u>	
51. SIGNATURE OF JURY <u>[Signature]</u>		52. SIGNATURE OF JUDGE <u>[Signature]</u>	
53. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		54. SIGNATURE OF DEFENSE <u>[Signature]</u>	
55. SIGNATURE OF JURY <u>[Signature]</u>		56. SIGNATURE OF JUDGE <u>[Signature]</u>	
57. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		58. SIGNATURE OF DEFENSE <u>[Signature]</u>	
59. SIGNATURE OF JURY <u>[Signature]</u>		60. SIGNATURE OF JUDGE <u>[Signature]</u>	
61. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		62. SIGNATURE OF DEFENSE <u>[Signature]</u>	
63. SIGNATURE OF JURY <u>[Signature]</u>		64. SIGNATURE OF JUDGE <u>[Signature]</u>	
65. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		66. SIGNATURE OF DEFENSE <u>[Signature]</u>	
67. SIGNATURE OF JURY <u>[Signature]</u>		68. SIGNATURE OF JUDGE <u>[Signature]</u>	
69. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		70. SIGNATURE OF DEFENSE <u>[Signature]</u>	
71. SIGNATURE OF JURY <u>[Signature]</u>		72. SIGNATURE OF JUDGE <u>[Signature]</u>	
73. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		74. SIGNATURE OF DEFENSE <u>[Signature]</u>	
75. SIGNATURE OF JURY <u>[Signature]</u>		76. SIGNATURE OF JUDGE <u>[Signature]</u>	
77. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		78. SIGNATURE OF DEFENSE <u>[Signature]</u>	
79. SIGNATURE OF JURY <u>[Signature]</u>		80. SIGNATURE OF JUDGE <u>[Signature]</u>	
81. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		82. SIGNATURE OF DEFENSE <u>[Signature]</u>	
83. SIGNATURE OF JURY <u>[Signature]</u>		84. SIGNATURE OF JUDGE <u>[Signature]</u>	
85. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		86. SIGNATURE OF DEFENSE <u>[Signature]</u>	
87. SIGNATURE OF JURY <u>[Signature]</u>		88. SIGNATURE OF JUDGE <u>[Signature]</u>	
89. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		90. SIGNATURE OF DEFENSE <u>[Signature]</u>	
91. SIGNATURE OF JURY <u>[Signature]</u>		92. SIGNATURE OF JUDGE <u>[Signature]</u>	
93. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		94. SIGNATURE OF DEFENSE <u>[Signature]</u>	
95. SIGNATURE OF JURY <u>[Signature]</u>		96. SIGNATURE OF JUDGE <u>[Signature]</u>	
97. SIGNATURE OF PROSECUTOR <u>[Signature]</u>		98. SIGNATURE OF DEFENSE <u>[Signature]</u>	
99. SIGNATURE OF JURY <u>[Signature]</u>		100. SIGNATURE OF JUDGE <u>[Signature]</u>	

NOTED 04000

RECEIVED
JAN 16 1920
BALTIMORE

0720 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Starford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Starford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Starve de Grace</i>		c. LENGTH OF STAY IN lb <i>Lifetime</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Warren St. Eft.</i>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Percy</i> Middle <i>Paul</i> Last <i>Jackson</i>		4. DATE OF DEATH Month <i>1</i> Day <i>25</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/4/1902</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Aberdeen High School</i>	
11. BIRTHPLACE (State or foreign country) <i>Starve de Grace, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Rufus Gallaway</i>		14. MOTHER'S MAIDEN NAME <i>Martha Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-09-7284</i>	
17. INFORMANT Address <i>Warren St. Eft.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Acute Coronary Thrombosis</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mesenteric Thrombosis</i> DUE TO			
(c) <i>Arteriosclerotic Heart disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Viral Pneumonitis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/11</i> , 19 <i>60</i> , to <i>1/25</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/25</i> , 19 <i>60</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		DATE SIGNED <i>1/27/60</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		ADDRESS (Street, city or town, state) <i>569 Revolution St. Starve de Grace, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/28/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Darlington Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stella J. Bullock</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 29 '60</i>	
ADDRESS <i>558 Reisterstown Rd. Starve de Grace, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OFFICE OF THE SECRETARY OF THE ARMY

1910

Very respectfully,
Yours very truly,
[Signature]
[Name]
[Title]
[Address]
[City]
[State]
[Country]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0721 CERTIFICATE OF DEATH

Reg. Dist. No.

00725

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE 24</u>	
		d. STREET ADDRESS <u>714 Revolution St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie M.</u> Middle <u></u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Memorial Hosp.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK MAGNESS</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Grant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>John Rithley</u>		18. ADDRESS <u>216 Sigeford Ave. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme malnutrition</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer large bowel & metastasis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u>JANUARY 30, 1960</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. M. K. Green</u> M.D.		ADDRESS (Street, city or town, state) <u>H. de S.</u> DATE SIGNED <u>1-30-60</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Churchville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brimington Rm, Harford Chan. Md.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>FEB 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0738 CERTIFICATE OF DEATH

Reg. Dist. No.

00726

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BEL AIR		c. LENGTH OF STAY IN 1b 5 year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BEL AIR		d. STREET ADDRESS MOORE'S MILL ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Moore's Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle ELIZABETH Last JOHNSTON		4. DATE OF DEATH Month JANUARY Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Johnston		14. MOTHER'S MAIDEN NAME MARY M. BLAKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Jean J. Myles		Address (sister) 302 Woodbourne Ave BALTIMORE 17, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive 9th ARTERIOsclerotic Vascular disease DUE TO (c) 5 or 10 Years		INTERVAL BETWEEN ONSET AND DEATH 1 or 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 6, 1960 to JANUARY 7, 1960 , that I last saw the deceased alive on JANUARY 7, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul S. Stonesifer Jr.		ADDRESS (Street, city or town, state) 115 FULFORD AVE.	
PHYSICIAN'S NAME (Type) PAUL S. STONESIFER, JR.		DATE SIGNED JAN. 7, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Vickner & Sons - Bacto 17 Md		24a. REC'D BY REGISTRAR JAN 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0722 CERTIFICATE OF DEATH

Reg. Dist. No.

00727

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>16 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NETTIE MARGARET KALINOWSKI</u>				4. DATE OF DEATH Month Day Year <u>JAN. 12 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/17/1901</u>	
9. AGE (In years lost birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Shamokin Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Stanley Baginski</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Rutynowicz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT (Address) <u>Nettie D. Padgett, Webster Village Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage due to Arteriosclerotic hypertensive C.V.D.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>60</u> , to <u>1/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>60</u> , and that death occurred at <u>9:15 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>			
DATE SIGNED <u>1/13/60</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				ADDRESS <u>Harford de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stanislawski</u>		22d. LOCATION (City, town, or county) (State) <u>Shamokin, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William P. H. Harford de Grace Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. RACE White		5. PLACE OF BIRTH Maryland	
6. DATE OF DEATH Jan 15 1918		7. TIME OF DEATH 10:30 AM		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED James H. Harris		12. SIGNATURE OF WITNESSES John Doe, Jane Doe		13. SIGNATURE OF PHYSICIAN Dr. John Smith		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF REGISTRAR John Doe	
16. DATE OF BIRTH Jan 15 1873		17. TIME OF BIRTH 10:30 AM		18. PLACE OF BIRTH Maryland		19. CAUSE OF BIRTH Heart Disease		20. MANNER OF BIRTH Natural	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESSES John Doe, Jane Doe		23. SIGNATURE OF PHYSICIAN Dr. John Smith		24. SIGNATURE OF CLERK John Doe		25. SIGNATURE OF REGISTRAR John Doe	
26. DATE OF BIRTH Jan 15 1873		27. TIME OF BIRTH 10:30 AM		28. PLACE OF BIRTH Maryland		29. CAUSE OF BIRTH Heart Disease		30. MANNER OF BIRTH Natural	
31. SIGNATURE OF DECEASED James H. Harris		32. SIGNATURE OF WITNESSES John Doe, Jane Doe		33. SIGNATURE OF PHYSICIAN Dr. John Smith		34. SIGNATURE OF CLERK John Doe		35. SIGNATURE OF REGISTRAR John Doe	
36. DATE OF BIRTH Jan 15 1873		37. TIME OF BIRTH 10:30 AM		38. PLACE OF BIRTH Maryland		39. CAUSE OF BIRTH Heart Disease		40. MANNER OF BIRTH Natural	
41. SIGNATURE OF DECEASED James H. Harris		42. SIGNATURE OF WITNESSES John Doe, Jane Doe		43. SIGNATURE OF PHYSICIAN Dr. John Smith		44. SIGNATURE OF CLERK John Doe		45. SIGNATURE OF REGISTRAR John Doe	
46. DATE OF BIRTH Jan 15 1873		47. TIME OF BIRTH 10:30 AM		48. PLACE OF BIRTH Maryland		49. CAUSE OF BIRTH Heart Disease		50. MANNER OF BIRTH Natural	
51. SIGNATURE OF DECEASED James H. Harris		52. SIGNATURE OF WITNESSES John Doe, Jane Doe		53. SIGNATURE OF PHYSICIAN Dr. John Smith		54. SIGNATURE OF CLERK John Doe		55. SIGNATURE OF REGISTRAR John Doe	
56. DATE OF BIRTH Jan 15 1873		57. TIME OF BIRTH 10:30 AM		58. PLACE OF BIRTH Maryland		59. CAUSE OF BIRTH Heart Disease		60. MANNER OF BIRTH Natural	
61. SIGNATURE OF DECEASED James H. Harris		62. SIGNATURE OF WITNESSES John Doe, Jane Doe		63. SIGNATURE OF PHYSICIAN Dr. John Smith		64. SIGNATURE OF CLERK John Doe		65. SIGNATURE OF REGISTRAR John Doe	
66. DATE OF BIRTH Jan 15 1873		67. TIME OF BIRTH 10:30 AM		68. PLACE OF BIRTH Maryland		69. CAUSE OF BIRTH Heart Disease		70. MANNER OF BIRTH Natural	
71. SIGNATURE OF DECEASED James H. Harris		72. SIGNATURE OF WITNESSES John Doe, Jane Doe		73. SIGNATURE OF PHYSICIAN Dr. John Smith		74. SIGNATURE OF CLERK John Doe		75. SIGNATURE OF REGISTRAR John Doe	
76. DATE OF BIRTH Jan 15 1873		77. TIME OF BIRTH 10:30 AM		78. PLACE OF BIRTH Maryland		79. CAUSE OF BIRTH Heart Disease		80. MANNER OF BIRTH Natural	
81. SIGNATURE OF DECEASED James H. Harris		82. SIGNATURE OF WITNESSES John Doe, Jane Doe		83. SIGNATURE OF PHYSICIAN Dr. John Smith		84. SIGNATURE OF CLERK John Doe		85. SIGNATURE OF REGISTRAR John Doe	
86. DATE OF BIRTH Jan 15 1873		87. TIME OF BIRTH 10:30 AM		88. PLACE OF BIRTH Maryland		89. CAUSE OF BIRTH Heart Disease		90. MANNER OF BIRTH Natural	
91. SIGNATURE OF DECEASED James H. Harris		92. SIGNATURE OF WITNESSES John Doe, Jane Doe		93. SIGNATURE OF PHYSICIAN Dr. John Smith		94. SIGNATURE OF CLERK John Doe		95. SIGNATURE OF REGISTRAR John Doe	
96. DATE OF BIRTH Jan 15 1873		97. TIME OF BIRTH 10:30 AM		98. PLACE OF BIRTH Maryland		99. CAUSE OF BIRTH Heart Disease		100. MANNER OF BIRTH Natural	

RECEIVED
JAN 15 1918
BALTIMORE, MD.

0723. CERTIFICATE OF DEATH

Reg. Dist. No.

00728

1. PLACE OF DEATH: a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARford Memorial</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Edgewood</u> d. STREET ADDRESS <u>3 KENARD ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLIFFORD</u> Middle <u>KAITH</u> Last <u>OF SR.</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1902</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frederick</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>SON.</u>		17. ADDRESS <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Pulmonary Edema</u> 420.0 DUE TO (b) <u>Coronary insufficiency, Liver Congestion</u> DUE TO (c) <u>Arterio Sclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 31</u> , 1959, to <u>JANUARY 12, 1960</u> , that I last saw the deceased alive on <u>Jan 11</u> , 1960, and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andre Weiss</u>		DATE SIGNED <u>114 W. Bel Air Ave. Aberdeen, Md</u>	
PHYSICIAN'S NAME (Type) <u>ANDRE WEISS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>11/5/60</u>	<u>OAK LAWN</u>	<u>BARTO Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. Heemann</u>		24a. REC'D BY REGISTRAR <u>6067 Harford Rd</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>JAN 20 '60</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0711

CERTIFICATE OF DEATH

Reg. Dist. No.

00729

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 WAKELEY TERRACE</u>				d. STREET ADDRESS <u>1210 WAKELEY TERRACE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>M.</u> Last <u>LEHR</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 6, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>SALINA, KANSAS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>DANIEL M. EVANS</u>				14. MOTHER'S MAIDEN NAME <u>CARDYN M. HEDGES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Edwin C. Kohan</u> Address <u>210 WAKELEY TERRACE BEL AIR, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma, Cervix</u> DUE TO (b) <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/31</u> , 19 <u>59</u> , to <u>1/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>60</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 966 Edgewood, Md.</u> DATE SIGNED <u>1/28/60</u>							
ACTUAL SIGNATURE <u>E. Lewis Foham</u> M.D.				PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, HARFORD CO., MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u> ADDRESS <u>W. Broadway + Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 1 1960</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: JAMES H. [unclear]]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>		<p>4. DATE OF BIRTH [Handwritten: 10-15-1875]</p>	
<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION [Handwritten: Clerk]</p>		<p>7. MARITAL STATUS [Handwritten: Married]</p>		<p>8. DATE OF DEATH [Handwritten: 11-10-1918]</p>	
<p>9. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>10. PLACE OF DEATH [Handwritten: Home]</p>		<p>11. CAUSE OF DEATH [Handwritten: Heart Disease]</p>		<p>12. MEDICAL HISTORY [Handwritten: High blood pressure]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Handwritten: J. H. [unclear]]</p>		<p>14. SIGNATURE OF WITNESS [Handwritten: [unclear]]</p>		<p>15. SIGNATURE OF DECEASED [Handwritten: [unclear]]</p>		<p>16. SIGNATURE OF REGISTRAR [Handwritten: [unclear]]</p>	

Let copies be made of this certificate and file in the files of the Department of Health.

10 MINUTES TO 12 MIDDAY

10 MINUTES TO 12 MIDDAY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0739 CERTIFICATE OF DEATH

Reg. Dist. No.

00730

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Romey E. McMillon</u>		4. DATE OF DEATH <u>Jan 25 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crop farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Rennick, Va</u>	
13. FATHER'S NAME <u>John R. McMillon</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>331X</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> (c) <u>69</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/24</u> , 19 <u>60</u> , to <u>1/26</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>1/26</u> , 19 <u>60</u> , and that death occurred at <u>630 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Darlington Md</u>	
PHYSICIAN'S NAME (Type) <u>DARLINGTON Md</u>		DATE SIGNED <u>1/25/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 26 1960 End of Trail Green Burial Co. Va</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. S. Bailey</u>		ADDRESS <u>Darlington Md</u>	
24a. RECEIVED BY REGISTRAR <u>FEB 1 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

00780

00780

WYOMING

1914

1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00731

0740

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Whiteford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) H. Clayton Merryman		4. DATE OF DEATH Jan. 29, 1960	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1870
9. AGE (In years birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen. Store	
11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry S. Merryman		14. MOTHER'S MAIDEN NAME Jane Ann Webb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT W. Edgar Merryman, Whiteford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26, 1960 to Jan 29, 1960 , that I last saw the deceased alive on Jan 29, 1960 , and that death occurred at 10:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Hyson M.D.		ADDRESS (Street, city or town, state) Fawn Grove, Pa.	
PHYSICIAN'S NAME (Type) Edward W. Hyson		DATE SIGNED Fawn Grove, Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-60	
22c. NAME OF CEMETERY OR CREMATORY Fawn Grove Meth.		22d. LOCATION (City, town, or county) (State) Fawn Grove, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth C. ...		ADDRESS Stewartstown, Pa.	
24a. REC'D BY REGISTRAR FEB 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Haus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOND

NAME OF DECEASED		DATE OF DEATH	
WILLIAM BOND		JAN 10 1900	
AGE		SEX	
60		M	
OCCUPATION		PLACE OF BIRTH	
LABORER		ENGLAND	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
TIME OF DEATH		PLACE OF DEATH	
10:00 AM		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. BOND		J. H. BOND	
DATE		PLACE	
JAN 10 1900		BALTIMORE	

0741

CERTIFICATE OF DEATH

Reg. Dist. No.

00732

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abirdeen Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abirdeen Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Kate L Miller</u> First Middle Last		4. DATE OF DEATH <u>Jan 12 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1874</u> 9. AGE (In years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Harford Co, Md, U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Geo. Garretson</u>	
14. MOTHER'S MAIDEN NAME <u>Idell Whitson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>812-26-5108</u>		INFORMANT <u>B. M. Miller</u> Address <u>Abirdeen MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Asthma</u> <u>434.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Natural</u> DUE TO (c) <u>Age</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 9, 1959</u> to <u>Jan 12, 1960</u> , that I last saw the deceased alive on <u>Jan 8, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. P. Lindgrass</u>		ADDRESS (Street, city or town, state) <u>Warrington Md</u>	
PHYSICIAN'S NAME (Type) <u>F. P. Lindgrass</u>		ADDRESS <u>Warrington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 15, 1960 Wesleyan Chapel Harford Co Md</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>	ADDRESS <u>Warrington Md</u>	24a. REC'D BY REGISTRAR <u>Jan 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>

00735

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1941

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0742

CERTIFICATE OF DEATH

00733

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural.</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Perryman</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>Fairfax</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/3/1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morgan Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Julian F. Mitchell Jr. - Aberdeen, Maryland.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Bladder</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>9 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-22-59</u> to <u>1-17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-17-60</u> , 19 <u> </u> , and that death occurred at <u>6:10</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Aberdeen Maryland</u> DATE SIGNED <u>1/18/60</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>		<u>Aberdeen Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grove Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barry</u>		ADDRESS <u>Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0724 CERTIFICATE OF DEATH

Reg. Dist. No.

00734

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cal</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARREDS GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>				d. STREET ADDRESS <u>91 N Main St</u>			
3. NAME OF DECEASED (Type or print) First <u>SENA</u> Middle <u>MOULDER</u> Last <u>MOULDER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1881</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phillip Fox Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Berry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Port Deposit, Miss Ida Jackson, 91 N. Main St. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia left upper lobe</u> DUE TO (c) <u>Poss. 10% Metastatic Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 wks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-10</u> , 19 <u>52</u> , to <u>1-16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JANUARY 16, 1960</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.H. Richards Jr.</u>				ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>1/16/60</u>			
PHYSICIAN'S NAME (Type) <u>G.H. Richards Jr., M.D.</u>							
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-20-1960</u>		<u>St. Marks</u>		<u>Perryville, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eda Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0743 CERTIFICATE OF DEATH

Reg. Dist. No. 00735

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>H.</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June, 17, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Magnolia, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Myers</u>				14. MOTHER'S MAIDEN NAME <u>Christine Herbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-14-2545</u>		17. INFORMANT <u>Mrs., Irene H. Myers, Edgewood, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Lymphatic Leukemia</u> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>59</u> , to <u>Jan 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Edgewood, Maryland.</u> ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D. <u>For 966 Edgewood, Md.</u> PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs Jr.</u> ADDRESS <u>Abingdon, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1900		BALTIMORE, MD	
AGE		SEX		RACE	
45		Male		White	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JANUARY 10, 1855		BALTIMORE, MD		JANUARY 10, 1880	
FATHER'S NAME		MOTHER'S NAME		EDUCATION	
JAMES H. HARRIS		MARY H. HARRIS		Common School	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Carpenter		Heart Disease		Natural	
PREVIOUS ILLNESS		DATE OF BURIAL		PLACE OF BURIAL	
None		JANUARY 12, 1900		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
J. H. HARRIS		J. H. HARRIS		JANUARY 10, 1900	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G259 3-28-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00736

0744

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air (Rural) c. LENGTH OF STAY IN 1b 31 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS 134 Brannon Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Jefferson First Middle Grover Last Nolen		4. DATE OF DEATH Month 1 Day 16 Year 1960						
5. SEX Male	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1885	9. AGE (In years last birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer (Retired) Plaster, (Cont.)	11. BIRTHPLACE (State or foreign country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME I'saac Nolen		14. MOTHER'S MAIDEN NAME Harriett Tollet		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 445-03-4437	17. INFORMANT Jerry A. Nolen Sr. Address 134 Brannon Rd. Aberdeen, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CEREBRAL THROMBOSIS, Terminating 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). Generalized Arteriosclerosis DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) According to autopsy due to degeneration of spinal cord. (vascular nature)							INTERVAL BETWEEN ONSET AND DEATH 3da	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:25AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED 1/16/60 ACTUAL SIGNATURE Willard P. Hudson M.D. FOREST HILL, MD. PHYSICIAN'S NAME (Type) WILLARD P. HUDSON M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/17/60		22c. NAME OF CEMETERY OR CREMATORY Prairie Grove Cemetery, Prairie Grove, Ark.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John E. Barringer ADDRESS Aberdeen, Maryland				24a. REC'D BY REGISTRAR DATE JAN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur L. K...		

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Age of Deceased [Illegible]		Sex [Illegible]	
Race [Illegible]		Marital Status [Illegible]	
Usual Residence [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Physician's Signature [Illegible]		Registrar's Signature [Illegible]	
Date of Certificate [Illegible]		Office of Registrar [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0745 CERTIFICATE OF DEATH

00737

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford/Cecil ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Perryville			
c. LENGTH OF STAY IN 1b 132 days				d. STREET ADDRESS Aberdeen Proving Ground			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aberdeen Proving Ground				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Ellen Potter				4. DATE OF DEATH Month Day Year January 1 19 60			
S. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 19 Aug. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months Days Hours Min. 4 12	
11. BIRTHPLACE (State or foreign country) Aberdeen, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Billie Sfr. HOOKY Potter, Jr.				14. MOTHER'S MAIDEN NAME Mrs. Sung Hi Yoo Potter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Box 366 Perryville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory dysfunction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral defects, congenital DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 132 days	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from 19 August, 19 59 , to 1 January, 19 60 , that I last saw the deceased alive on 1 January, 19 60 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas J. Fraher MD M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Thomas J. Fraher, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		1-4-1960		Principio		Principio Furnace Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee G. Patterson + Son Perryville, Md				24a. REC'D BY REGISTRAR DATE JAN 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050221X02

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G256 2-17-60 et

CERTIFICATE OF DEATH

00738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Darlington</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Nelson</u> Last <u>Bushbury</u> 4. DATE OF DEATH Month <u>Jan</u> , Day <u>29</u> , Year <u>1960</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 22, 1885</u> 9. AGE (In years last birthday) <u>74</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer on Farm</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> 11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Robert Nelson Bushbury</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>Mo 220-05-3728</u> INFORMANT <u>Burdell Bushbury</u> Address <u>Darlington, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 14</u> , 19 <u>59</u> , to <u>Jan. 29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 28</u> , 19 <u>60</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>569 Revolution St. Haves de Grace, Md.</u> DATE SIGNED <u>1/30/60</u> ACTUAL SIGNATURE <u>George T. Stansbury</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 2 1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Hosanna Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Bailey</u> ADDRESS <u>Darlington Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

0342

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00739

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>0747</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Lancaster</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lancaster</u> <u>75x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 7</u>		d. STREET ADDRESS <u>22 Parkside Ave.,</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>S.</u> Last <u>Robey</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1910</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Lancaster, Pa.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>George B. Sachs</u>		14. MOTHER'S MAIDEN NAME <u>Lillie M. Musselman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Robert E. Robey</u>		Address <u>Lancaster, Pa.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto onto type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1-18</u> <u>60</u> p. m. <u>1930</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 7 + 24</u>	20f. (City or town) (County) (State) <u>Edgewood Harford MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel A...</u> DATE SIGNED <u>1-18-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Jan. 19, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Groff Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Lancaster, Penna.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McBrum</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>21 YEARS</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse L Robinson</u>		4. DATE OF DEATH Month Day Year <u>January 5 1969</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12-5-50</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>Harford Co MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Louis B Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Marian Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> 17. INFORMANT Address <u>Charles C Robinson Bel Air MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive & Vascular</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air MD</u> DATE SIGNED EXAMINER'S NAME (Type) <u>Gerald E Palmer - M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-5-60</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>Jan 7/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u> 22d. LOCATION (City, town, or county) (State) <u>Joppa Rural Harford MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Bel Air MD</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE JAN 7 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

Item 18 Film 257
2-29-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00741

1. PLACE OF DEATH a. COUNTY Harford 0725 MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Joppa		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Billy G. Rudd			4. DATE OF DEATH January 13 19 60		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July, 14, 1937		
9. AGE (In years last birthday) 22 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		
11. BIRTHPLACE (State or foreign country) Fawn Grove, Pa.,			12. CITIZEN OF WHAT COUNTRY? U.S.A.,		
13. FATHER'S NAME James Rudd			14. MOTHER'S MAIDEN NAME Orpha Rigsby		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-43-4580		
17. INFORMANT Mrs., John Steele Address Joppa, Md.,			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 353.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Broncho pneumonia DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William J. Steele			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) William J. Steele			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 1/14/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Jan 15, 1959		
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial			22d. LOCATION (City, town, or country) (State) Abingdon, Harford, Md.,		
23. FUNERAL DIRECTOR Howard K. Brown Jr. ADDRESS Abingdon, Maryland.			24a. REC'D BY REGISTRAR JAN 18 '60		
24b. REGISTRAR'S SIGNATURE Arthur S. Hume					

2582

1901

Shoe Factory

1945

617 2000U

1950

1. 1944

(John) Henry

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00742

1. PLACE OF DEATH a. COUNTY <u>Harford</u> 0748 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>		c. LENGTH OF STAY IN 1b <u>31 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Allen</u> Last <u>Rutherford</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-28</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refineries</u>	
11. BIRTHPLACE (State or foreign country) <u>Rocks Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Rutherford</u>		14. MOTHER'S MAIDEN NAME <u>Bessie May Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-26-2526</u>	
17. INFORMANT <u>Mrs Evelyn E. Rutherford</u>		Address <u>Rocks, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASW Cerebrum</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self</u>	
20c. TIME OF INJURY Month, Day, Year <u>9</u> Hour <u>am</u> <u>1-20</u> <u>1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rocks Harford Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Leroy C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-21-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Centre</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurtz</u>		ADDRESS <u>Garrettsville, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>0749</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> <u>18 mo</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 7</u>				d. STREET ADDRESS <u>Route 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grover M.</u> Middle <u>Shepherd</u> Last <u></u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-26-90</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>		11. BIRTHPLACE (State or foreign country) <u>W.Va.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>James Shepard</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mc Vey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>235-10-7865</u>		17. INFORMANT <u>Tracey Shepard</u>		Address <u>Joppa, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Bel Air, Md</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Jan. 17, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tyre F.H.,</u>		22d. LOCATION (City, town, or county) (State) <u>Mt., Hope, Fayette Co., W.Va.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u> ADDRESS <u>Abingdon, Maryland.</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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Thomas D. Arnold, *archivist@uic.edu*

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1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00744

CERTIFICATE OF DEATH

0726

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		TOWN <u>Harre de Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>514 Revolution Street</u>				STREET ADDRESS (If rural give location) <u>514 Revolution Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>W.</u> (Last) <u>Skinner</u>				(Month) <u>1</u> (Day) <u>20</u> (Year) <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2/22/1894</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce Store</u>		11. BIRTHPLACE (State or foreign country) <u>Harre de Grace</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Norace Skinner</u>				14. MOTHER'S MAIDEN NAME <u>Rose Herman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>215-09-5194</u>		17. INFORMANT & ADDRESS <u>Mrs Marion Swan</u> <u>1428 Army St Washington DC DC</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
140.0 IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma of the Upper Lip</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25</u> , 19 <u>59</u> , to <u>1/19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>60</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city, town, state) <u>569 Revolution St Harre de Grace, Md</u>			
DATE <u>1/25/60</u>				DATE SIGNED <u>1/20/60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/25/60</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		ADDRESS <u>Harre de Grace</u>	
DATE <u>JAN 26 '60</u>							

CERTIFICATE OF DEATH

1938

Dec. 1938

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CLERGY

15. SIGNATURE OF OTHER

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INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased.

2. The cause of death should be stated in full, and the immediate cause should be stated first.

3. The place of death should be stated, and the time of death should be stated in full.

4. The signature of the physician or other qualified person should be written in full.

5. The signature of the registrar should be written in full.

6. The signature of the witnesses should be written in full.

7. The signature of the funeral home should be written in full.

8. The signature of the clergy should be written in full.

9. The signature of other persons should be written in full.

10. The signature of the deceased should be written in full.

11. The signature of the family should be written in full.

12. The signature of the neighbors should be written in full.

13. The signature of the community should be written in full.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00745**

1. PLACE OF DEATH a. COUNTY <u>Harford</u> 0750 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>RD 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Daniel</u> First <u>Hollis</u> Middle <u>Smith</u> Last 4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1960</u>			5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-29-1900</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Labour</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u> 11. BIRTHPLACE (State or foreign country) <u>Harford County</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>George Giles</u> 14. MOTHER'S MAIDEN NAME <u>Della Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>212-18-9081</u> 17. INFORMANT <u>Mrs. Della Briggs - R.F.N.</u> Address <u>Aberdeen Md</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>2-3-60</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1-5-1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Greenspring Cem.</u> 22d. LOCATION (City, town, or county) <u>Level, Harford C. Md.</u> (State) _____		24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u> DATE <u>JAN 6 '60</u> 24b. REGISTRAR'S SIGNATURE			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Bullock - Harford</u> ADDRESS _____					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00746

0751

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN 1b 40 yrs.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Abingdon	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle P. Last Sonberg		4. DATE OF DEATH Month Jan. Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Czech
12. CITIZEN OF WHAT COUNTRY? U.S.A.,			
13. FATHER'S NAME Alexander Pouska		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-34-1107	
17. INFORMANT Henry A. Sonberg		Address Abingdon, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Inter cerebral Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/26 , 19 57 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred at A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Louis Kahan		ADDRESS (Street, city or town, state) Box 966 Edgewood Md DATE SIGNED 1/30/60	
PHYSICIAN'S NAME (Type) E. Louis Kahan		Edgewood Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 1 1960	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial	22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McConn		ADDRESS Abingdon, Md.,	
24a. REC'D BY REGISTRAR FEB 3 1960		DATE 1/30/60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thayer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1950		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
Jan 1, 1950		Baltimore		[Seal]	

0727 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Edgewood Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 071 HARFORD MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STANLEY E STANDIFORD Sr		4. DATE OF DEATH Month Day Year JANUARY 31 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Chem. Plant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William K. Standiford		14. MOTHER'S MAIDEN NAME P. May Amoss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW		16. SOCIAL SECURITY NO. 22022-0758	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A.S.C.V.D. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/31 , 19 60 to 1/31 , 19 60 that I last saw the deceased alive on JANUARY 31 , 19 60 , and that death occurred at 12:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Harre de Grace, Md. DATE SIGNED 1/31/60 ACTUAL SIGNATURE Edward C. Choem PHYSICIAN'S NAME (Type) Edward C. Choem, M.D. for Dr. Simon			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Edward K. Choem ADDRESS Abingdon, Md.,		24a. REC'D BY REGISTRAR DATE FEB 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

1 day
2 years

A. S. C. V. 4
C. S. C. V. 4

Edward C. Lee, and John Simon
Edward C. Lee, and John Simon
1/21 1/21 1/21

Washington, D. C.
January 1, 1911

00748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Fallston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH					
First Middle Last John Herman Stempel				Month Day Year Jan 12, 19 60					
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 15, 1883		76 yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>T. J. Stempel</i>	14. MOTHER'S MAIDEN NAME <i>Henrietta Kamtman</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address Miss Anna D. Stempel, Fallston, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	Coronary Thrombosis	Sudden
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Due to coronary artery disease.	?
	DUE TO	
	(c) Generalized arteriosclerosis.	?

18.	PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	19. WAS AUTOPSY PERFORMED?
		YES <input type="checkbox"/> NO <input type="checkbox"/>

MEDICAL CERTIFICATE	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
	20c. TIME OF INJURY	Month,	Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
	Hour o. m. p. m.		19	While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		

21. I certify that I attended the deceased from Nov., 1956, to Jan 12, 1960, that I last saw the deceased alive on Dec. 3, 1959, and that death occurred at M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE Willard P. Hudson M.D. Forest Hill, Md. Jan. 12, 1960

PHYSICIAN'S NAME (Type) Willard P. Hudson M.D. Forest Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/15/1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 15 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kruze</i>

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 10 1900	
AGE 38		SEX M	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION LABORER	
CAUSE OF DEATH DIPHTHERIA		PLACE OF DEATH HOME	
DATE OF BURIAL JAN 12 1900		PLACE OF BURIAL CATHOLIC CEMETERY	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS	
DATE OF REGISTRATION JAN 10 1900		PLACE OF REGISTRATION BALTIMORE, MD	

CERTIFICATE OF DEATH

Reg. Dist. No.

0728

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>220 S Stokes</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Mathew Taylor Jr.</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 31 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXX 9/24/07</u>	9. AGE (In years last birthday) <u>52</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Mail Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence M. Taylor Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Maude M. Lucas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW. #2</u>				16. SOCIAL SECURITY NO. <u>Lawrence M. Taylor Sr. Havre de Grace, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>163X</u> DUE TO <u>Carcinoma of right lower lobe of the lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>?</u> (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 12th 1960</u> to <u>Jan. 31st 1960</u> that I last saw the deceased alive on <u>JANUARY 31, 1960</u> and that death occurred at <u>10:11 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. 1/31/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				DATE SIGNED <u>1/31/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				24a. REC'D BY REGISTRAR <u>John G. Tarring</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>Edward C. Lee, M.D.</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>51</i></p>		<p>4. DATE OF BIRTH <i>Jan. 31, 1884</i></p>		<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>6. OCCUPATION <i>Physician</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>Feb. 1, 1935</i></p>		<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Myocardial infarction</i></p>	
<p>11. MEDICAL HISTORY <i>None</i></p>		<p>12. PRESENT ILLNESS <i>None</i></p>		<p>13. DATE OF ONSET <i>None</i></p>		<p>14. DATE OF TERMINATION <i>None</i></p>		<p>15. DATE OF INTERMENT <i>None</i></p>	
<p>16. SIGNATURE OF PHYSICIAN <i>Edward C. Lee, M.D.</i></p>		<p>17. SIGNATURE OF WITNESS <i>John W. Brown</i></p>		<p>18. SIGNATURE OF DECEASED <i>Edward C. Lee</i></p>		<p>19. SIGNATURE OF NEXT OF KIN <i>John W. Brown</i></p>		<p>20. SIGNATURE OF REGISTRAR <i>John W. Brown</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

CERTIFICATE OF DEATH

Reg. Dist. No.

00750

0729

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PORT DEPOSIT</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>254 N. MAIN ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Harris V. Townley</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 1 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/10/08</u>	
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Tousey Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Callie Hickenbottom</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Helen Harris</u> Address <u>240 N. MAIN ST. PORT DEPOSIT, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic Cerebral Vascular Disease</u> DUE TO (c) <u>Arterio sclerotic Cerebral Vascular Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/30</u> , 19 <u>59</u> , to <u>1/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>60</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>529 Revolution St. Haver de Grace, Md.</u> DATE SIGNED <u>1/2/60</u>							
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-4-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jones Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u> ADDRESS <u>Perryville, Md</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR A BOARDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. JONES		2. SEX Male		3. RACE White		4. DATE OF BIRTH 1/1/1900		5. PLACE OF BIRTH Baltimore, Md.	
6. DATE OF DEATH 1/1/1950		7. PLACE OF DEATH Baltimore, Md.		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural		10. SIGNATURE OF DECEASED J. J. JONES	
11. SIGNATURE OF DECEASED J. J. JONES		12. SIGNATURE OF DECEASED J. J. JONES		13. SIGNATURE OF DECEASED J. J. JONES		14. SIGNATURE OF DECEASED J. J. JONES		15. SIGNATURE OF DECEASED J. J. JONES	
16. SIGNATURE OF DECEASED J. J. JONES		17. SIGNATURE OF DECEASED J. J. JONES		18. SIGNATURE OF DECEASED J. J. JONES		19. SIGNATURE OF DECEASED J. J. JONES		20. SIGNATURE OF DECEASED J. J. JONES	
21. SIGNATURE OF DECEASED J. J. JONES		22. SIGNATURE OF DECEASED J. J. JONES		23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF DECEASED J. J. JONES		25. SIGNATURE OF DECEASED J. J. JONES	
26. SIGNATURE OF DECEASED J. J. JONES		27. SIGNATURE OF DECEASED J. J. JONES		28. SIGNATURE OF DECEASED J. J. JONES		29. SIGNATURE OF DECEASED J. J. JONES		30. SIGNATURE OF DECEASED J. J. JONES	
31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF DECEASED J. J. JONES		33. SIGNATURE OF DECEASED J. J. JONES		34. SIGNATURE OF DECEASED J. J. JONES		35. SIGNATURE OF DECEASED J. J. JONES	
36. SIGNATURE OF DECEASED J. J. JONES		37. SIGNATURE OF DECEASED J. J. JONES		38. SIGNATURE OF DECEASED J. J. JONES		39. SIGNATURE OF DECEASED J. J. JONES		40. SIGNATURE OF DECEASED J. J. JONES	
41. SIGNATURE OF DECEASED J. J. JONES		42. SIGNATURE OF DECEASED J. J. JONES		43. SIGNATURE OF DECEASED J. J. JONES		44. SIGNATURE OF DECEASED J. J. JONES		45. SIGNATURE OF DECEASED J. J. JONES	
46. SIGNATURE OF DECEASED J. J. JONES		47. SIGNATURE OF DECEASED J. J. JONES		48. SIGNATURE OF DECEASED J. J. JONES		49. SIGNATURE OF DECEASED J. J. JONES		50. SIGNATURE OF DECEASED J. J. JONES	
51. SIGNATURE OF DECEASED J. J. JONES		52. SIGNATURE OF DECEASED J. J. JONES		53. SIGNATURE OF DECEASED J. J. JONES		54. SIGNATURE OF DECEASED J. J. JONES		55. SIGNATURE OF DECEASED J. J. JONES	
56. SIGNATURE OF DECEASED J. J. JONES		57. SIGNATURE OF DECEASED J. J. JONES		58. SIGNATURE OF DECEASED J. J. JONES		59. SIGNATURE OF DECEASED J. J. JONES		60. SIGNATURE OF DECEASED J. J. JONES	
61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF DECEASED J. J. JONES		63. SIGNATURE OF DECEASED J. J. JONES		64. SIGNATURE OF DECEASED J. J. JONES		65. SIGNATURE OF DECEASED J. J. JONES	
66. SIGNATURE OF DECEASED J. J. JONES		67. SIGNATURE OF DECEASED J. J. JONES		68. SIGNATURE OF DECEASED J. J. JONES		69. SIGNATURE OF DECEASED J. J. JONES		70. SIGNATURE OF DECEASED J. J. JONES	
71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF DECEASED J. J. JONES		73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF DECEASED J. J. JONES		75. SIGNATURE OF DECEASED J. J. JONES	
76. SIGNATURE OF DECEASED J. J. JONES		77. SIGNATURE OF DECEASED J. J. JONES		78. SIGNATURE OF DECEASED J. J. JONES		79. SIGNATURE OF DECEASED J. J. JONES		80. SIGNATURE OF DECEASED J. J. JONES	
81. SIGNATURE OF DECEASED J. J. JONES		82. SIGNATURE OF DECEASED J. J. JONES		83. SIGNATURE OF DECEASED J. J. JONES		84. SIGNATURE OF DECEASED J. J. JONES		85. SIGNATURE OF DECEASED J. J. JONES	
86. SIGNATURE OF DECEASED J. J. JONES		87. SIGNATURE OF DECEASED J. J. JONES		88. SIGNATURE OF DECEASED J. J. JONES		89. SIGNATURE OF DECEASED J. J. JONES		90. SIGNATURE OF DECEASED J. J. JONES	
91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF DECEASED J. J. JONES		93. SIGNATURE OF DECEASED J. J. JONES		94. SIGNATURE OF DECEASED J. J. JONES		95. SIGNATURE OF DECEASED J. J. JONES	
96. SIGNATURE OF DECEASED J. J. JONES		97. SIGNATURE OF DECEASED J. J. JONES		98. SIGNATURE OF DECEASED J. J. JONES		99. SIGNATURE OF DECEASED J. J. JONES		100. SIGNATURE OF DECEASED J. J. JONES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0730

CERTIFICATE OF DEATH

Reg. Dist. No.

00751

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md.		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Francis (Frank) I. Wheeler		4. DATE OF DEATH Month January Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 23, 1874
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sylvester Wheeler		14. MOTHER'S MAIDEN NAME Martha Glackin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT John Webster		Address Pylesville RD, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Thrombosis on 1/13/1960 DUE TO (c) Chronic Cardio-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 16 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. f. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 27 , 19 59 , to Jan. 29 , 19 60 , that I last saw the deceased alive on January 28 , 19 60 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard P. Hudson M.D.		ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED January 29, 1960	
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		Forest Hill, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 1, 1960	22c. NAME OF CEMETERY OR CREMATORY St. Marys Catholic	22d. LOCATION (City, town, or county) (State) Pylesville, Harford Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Hudson		ADDRESS Stewartstown, Pa.	
24a. REC'D BY REGISTRAR DATE FEB 2 '60		24b. REGISTRAR'S SIGNATURE Clarence S. ...	

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Edward Taylor		2. SEX Male		3. AGE 35	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Clerk		6. MARITAL STATUS Single	
7. DATE OF DEATH Jan 15, 1920		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Pneumonia		11. DISEASE OR INJURY Pneumonia		12. MEDICAL HISTORY None	
13. SIGNATURE OF PHYSICIAN J. H. Smith		14. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		15. SIGNATURE OF DECEASED None	
16. SIGNATURE OF REGISTRAR J. H. Smith		17. SIGNATURE OF CLERK J. H. Smith		18. SIGNATURE OF DECEASED None	
19. SIGNATURE OF DECEASED None		20. SIGNATURE OF DECEASED None		21. SIGNATURE OF DECEASED None	
22. SIGNATURE OF DECEASED None		23. SIGNATURE OF DECEASED None		24. SIGNATURE OF DECEASED None	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF DECEASED None		27. SIGNATURE OF DECEASED None	
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37. SIGNATURE OF DECEASED None		38. SIGNATURE OF DECEASED None		39. SIGNATURE OF DECEASED None	
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82. SIGNATURE OF DECEASED None		83. SIGNATURE OF DECEASED None		84. SIGNATURE OF DECEASED None	
85. SIGNATURE OF DECEASED None		86. SIGNATURE OF DECEASED None		87. SIGNATURE OF DECEASED None	
88. SIGNATURE OF DECEASED None		89. SIGNATURE OF DECEASED None		90. SIGNATURE OF DECEASED None	
91. SIGNATURE OF DECEASED None		92. SIGNATURE OF DECEASED None		93. SIGNATURE OF DECEASED None	
94. SIGNATURE OF DECEASED None		95. SIGNATURE OF DECEASED None		96. SIGNATURE OF DECEASED None	
97. SIGNATURE OF DECEASED None		98. SIGNATURE OF DECEASED None		99. SIGNATURE OF DECEASED None	
100. SIGNATURE OF DECEASED None		101. SIGNATURE OF DECEASED None		102. SIGNATURE OF DECEASED None	

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X
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9—Film G255-2/1/60-mnb

0753

CERTIFICATE OF DEATH

Reg. Dist. No.

00752

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON (RURAL)</u>				c. LENGTH OF STAY IN 1b <u>17 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGHES RD RD#2</u>				d. STREET ADDRESS <u>RD#2 HUGHES Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARTER CRAWFORD WITT</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 14 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 29, 1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>EDMOND WITT</u>				14. MOTHER'S MAIDEN NAME <u>POLLY ELDRIDGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>246-28-2188</u>			
17. INFORMANT Address <u>NANNIE WITT (SAME)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>BRONCHIAL PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROSIS - CONGESTIVE</u> DUE TO <u>HEART FAILURE</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>JAN 4</u> , 19 <u>60</u> , to <u>JAN 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 13</u> , 19 <u>60</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. <u>307 Hickox</u> <u>JAN 14, 1960</u> PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u> <u>BELAIR, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 17, 1960 Reubens, M. Cem Harford Co Md</u>				22b. DATE THEREOF _____			
22c. NAME OF CEMETERY OR CREMATORY _____				22d. LOCATION (City, town, or county) _____ (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H & Bailey, Darlington, Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>JAN 19 60</u> DATE _____		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krupa</u>	

CERTIFICATE OF DEATH

1957

10075

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		MEDICAL HISTORY _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS INFORMATION. IT IS THE RESPONSIBILITY OF THE PHYSICIAN AND CORONER TO PROVIDE THE NECESSARY INFORMATION TO THE DEPARTMENT. IT IS THE RESPONSIBILITY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS INFORMATION. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS INFORMATION. IT IS THE RESPONSIBILITY OF THE PHYSICIAN AND CORONER TO PROVIDE THE NECESSARY INFORMATION TO THE DEPARTMENT. IT IS THE RESPONSIBILITY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS INFORMATION.